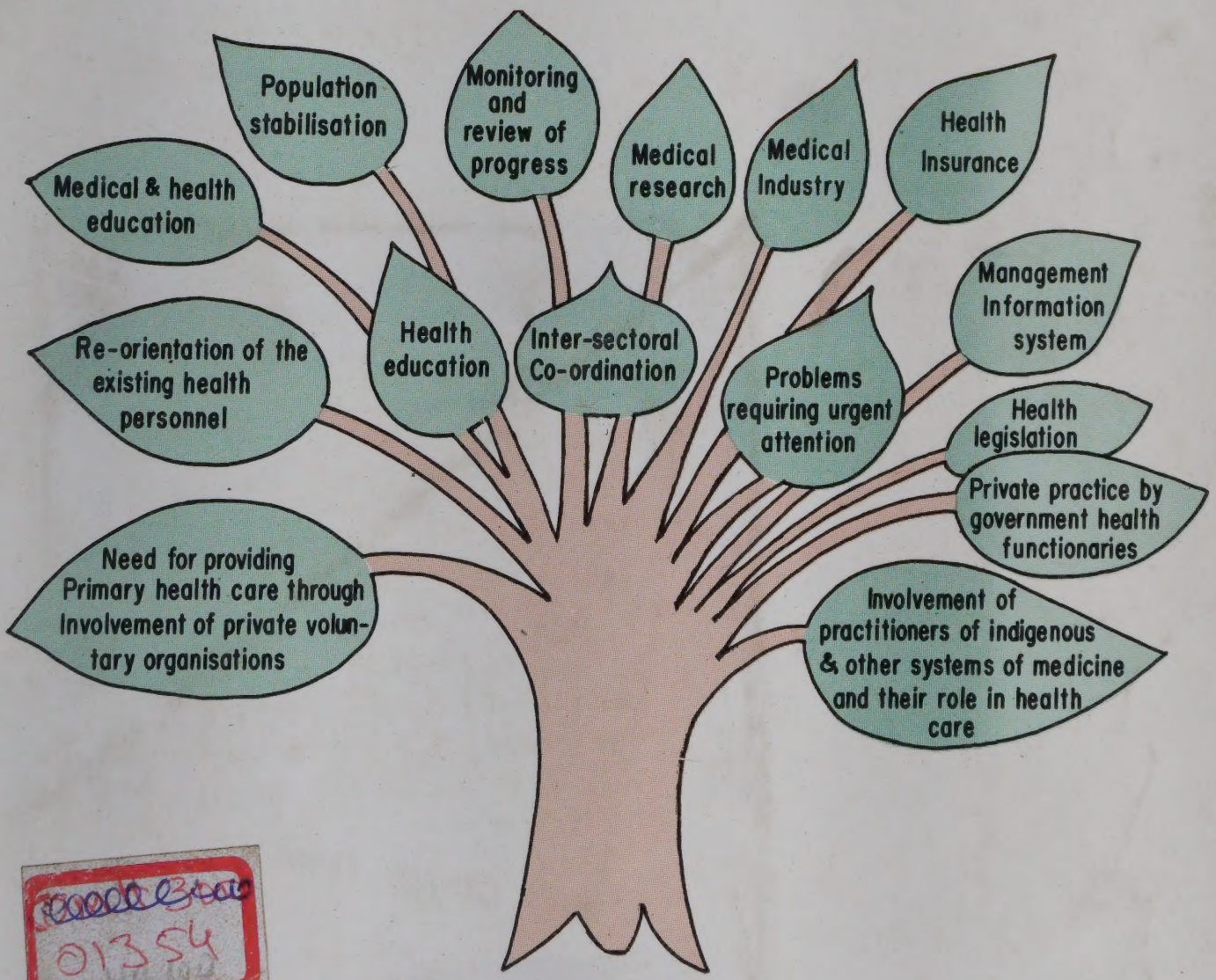
ELEMENTS OF NATIONAL HEALTH POLICY



Voluntary Health Association of India

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ELEMENTS OF NATIONAL HEALTH POLICY

In 1983, the Government of India presented a statement on National Health Policy. The new policy confirms the trend in favour of restructuring the health services in a way that will balance curative, preventive and promotive aspects. The health services will be linked to a hierarchy of referral services and integrated with human development and poverty alleviation programmes.

The main provisions of the National Health Policy are briefly summarized below:

I. PRIMARY HEALTH CARE

The aim is to provide within a phased, time bound programme, a well-dispersed network of comprehensive primary health care services. These will be integrally linked with the extension and health education approach which emphasizes that most health problems can be effectively handled and resolved by the people themselves, with the organised support of volunteers, auxiliaries, para-medicals and adequately trained multi-purpose workers, both male and female, of various grades of skill and competence.

(a) Involving Village Health guides

This is essential for the effective implementation of the primary health care approach. The village health guides should be selected by the communities and enjoy their confidence. Their functioning should be related to definitive action plans for translating medical and health knowledge into action. Only simple and inexpensive interventions which can be readily implemented by persons who have undergone short periods of training should be used.

(b) Community Participation

The success of the decentralised primary health care system would depend vitally on the organised building up of both individual self-reliance and effective community participation.

PRIMARY HEALTH CARE

AIMS AT

- Providing universal, comprehensive Primary Health Care Services relevant to actual needs and priorities of community
- Achieving self reliance and effective community participation.

THROUGH

- Community Participation
- Equitable distribution of resources
- Appropriate Technology
- Multi sectoral approach

TO PROVIDE

- Promotion of food supplies and nutrition
- Health Education
- Safe water supply and Basic Sanitation
- Mother & Child Health and Family Planning
- Immunization
- Prevention & Control of endemic diseases
- Treatment of common diseases & Injuries
- Provision of essential drugs

(c) Establishment of Referral System

The decentralisation of services would require the establishment of a well-worked-out referral system to provide adequate expertise at the various levels of the organisational set up nearest to the community. This would check the existing tendency to rush towards the curative centres in the urban areas.

(d) Sanitary-cum-Epidemiological Stations

It is important to establish a nationwide chain to collect and disburse information which will need health interventions. It will be necessary to establish these stations between different levels of the hierarchical structure. These stations would participate in the integrated action plans to eradicate and control diseases besides tackling specific local environmental health problems.

(e) Domiciliary Care and Field Camps

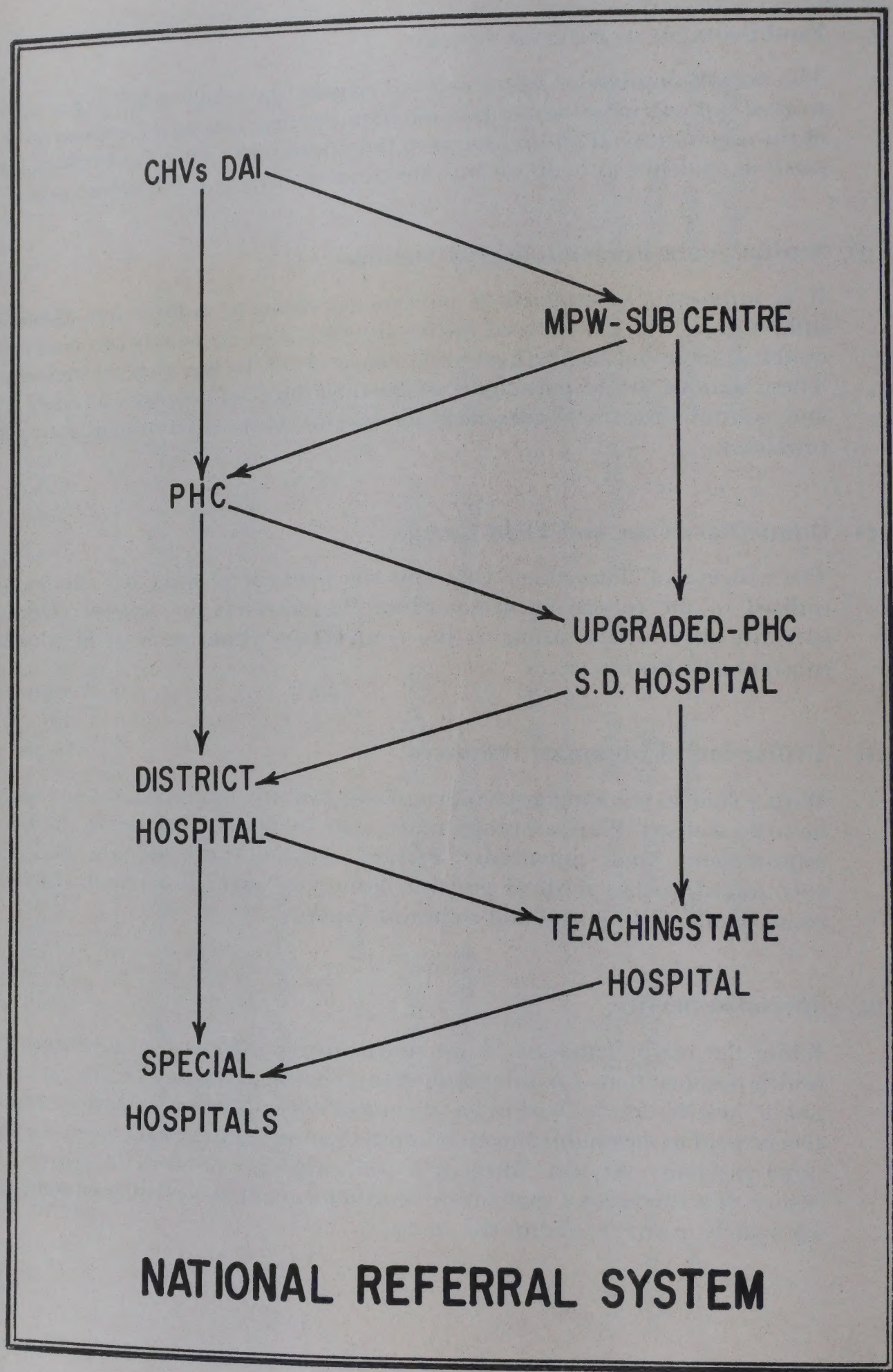
The concept of domiciliary care and the field-camp approach should be utilised to the fullest extent to reduce the pressures on curative centres, specially in efforts relating to the control and eradication of blindness, tuberculosis, leprosy etc.

(f) Utilisation of untapped resources

With a view to reducing governmental expenditure, untapped resources may be fully utilised. Planned programmes may be devised, related to the local requirements and potentials. Private medical professionals may be encouraged to start medical practice. Voluntary agencies active in the field must be offered financial and technical support.

(g) Specialist Service

While the major emphasis is on restructuring the existing governmental health organisations for providing comprehensive primary health care and public health services, within an integrated referral system, attention should also be paid to the establishment of centres equipped to provide speciality and super-speciality services, through a well-dispersed network of centres, to ensure that the present and future requirements of specialist treatment are adequately available within the country.



NATIONAL REFERRAL SYSTEM

(h) Programme for disabled

A special coordinated programme should be launched to provide mental health care as well as medical care and the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind and physically disabled etc.

II. REORIENTATION OF THE EXISTING HEALTH PERSONNEL

A dynamic process of change and innovation is required to be brought about in the entire approach to health manpower development, ensuring the emergence of fully integrated bands of workers functioning within the 'Health Team' framework.

III. PRIVATE PRACTICE BY GOVERNMENT FUNCTIONARIES

The system of private practice by medical personnel in government service, providing at the same time for payment of appropriate compensatory non-practising allowance should be encouraged.

IV. ROLE OF INDIGENOUS PRACTITIONERS AND OTHER SYSTEMS OF MEDICINE IN HEALTH CARE

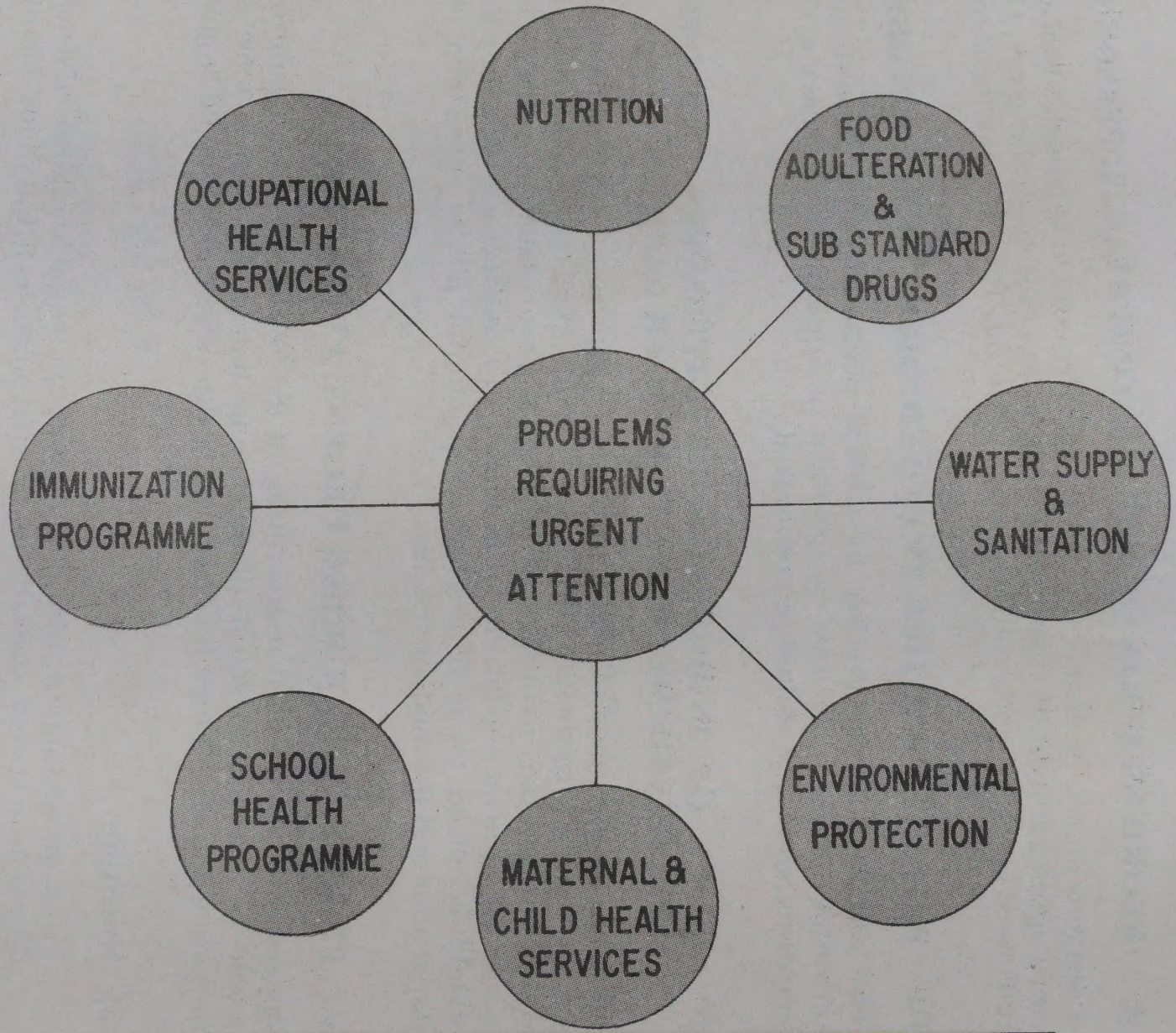
India has a large stock of health manpower comprising private practitioners in various systems of medicine. This resource has not so far been adequately utilised. It is therefore necessary to initiate organised measures to enable each of these various systems of medicine and health care to develop in accordance with its genius. Efforts should be made to move towards a meaningful phased integration of the indigenous and the modern systems.

V. PROBLEMS REQUIRING URGENT ATTENTION

Besides the recommended restructuring of the health services infrastructure, it would be necessary to devote planned, time bound, attention to some of the important inputs required for improved health care. Priority should be given to:

(a) Nutrition

To ensure adequate nutrition for all the population through a well-developed distribution system, specially in the rural areas and urban slums. The overall strategy would involve organised efforts to improve the purchasing power of the poorer sections of the society. Measures to improve eating habits and scientific utilisation of available food materials would require implementation



PROBLEMS REQUIRING URGENT ATTENTION

(b) Prevention of food adulteration and maintenance of quality of drugs

Stringent measures need to be taken to check and prevent the adulteration and contamination of foods at the various stages of their production, processing, storage, transport, distribution etc.

(c) Water supply and sanitation

The provision of safe drinking water and the disposal of waste waters, human and animal wastes, both in urban and rural areas, must constitute an integrated package.

(d) Environmental protection

It would be necessary to ensure against health hazards. Environmental appraisal procedures must be developed and strictly applied in according clearance to the various developmental projects.

(e) Immunization programme

It is necessary to launch an organised, nationwide immunization programme, aimed at cent-per-cent coverage of targetted population groups with vaccines against preventable communicable diseases.

(f) Maternal and Child Health Services

Highest priority should be given to launching special programmes for the improvement of maternal and child health with special focus on the less privileged sections of society.

(g) School Health Programmes

Organised School Health Programmes, integrally linked to the general, preventive and curative services, would need to be established within a time-bound programme.

(h) Occupational health services

The centre and the states must introduce occupational health services to reduce morbidity, disabilities, and mortality and thus promote better health and increased welfare and productivity on all fronts.

VI. HEALTH EDUCATION

The efforts at various fronts would bear only marginal results unless nationwide health education programmes, backed by appropriate communication strategies, are launched to provide health information in easily understandable form. This would motivate the development of an attitude for healthy living. The health education programme should be supplemented by health, nutrition and population education programmes in all educational institutions, at various levels. Simultaneously, efforts need to be made to promote universal education, specially adult and family education.

VII. HEALTH INFORMATION SYSTEM

The building up of a well-conceived health information system is necessary for assessing medical and health manpower requirements and taking timely decisions, on a continuing basis, regarding the manpower requirements in the future.

VIII. MEDICAL INDUSTRY

The available know-how should be adequately exploited to increase the production of essential and life saving drugs and vaccines of proven quality to fully meet the national requirements. In view of the low cost of indigenous and herbal medicines, organised efforts may be launched to establish herbal gardens, producing drugs of certified quality and making them easily available.

IX. HEALTH INSURANCE

It would be necessary to devise well-considered health insurance schemes, on a statewise basis, for mobilising additional resources for health promotion and ensuring that the community shares the cost of the services, in keeping with its paying capacity.

X. HEALTH LEGISLATION

It is necessary to urgently review all existing legislation and work towards a unified, comprehensive legislation in the health field, enforceable all over the country.

XI. MEDICAL RESEARCH

Priority attention should be devoted to the resolution of problems relating to the containment and eradication of the existing, widely prevalent diseases as well as to deal with emerging health problems.

Goals for Health and Family Welfare Programmes

Sl. No.	Indicator	Current level	Goals		
			1985	1990	2000
1.	Infant mortality rate	Rural 136 (1978)*	122		
		Urban 70 (1978)	60		
		Total 125 (1978)	106	87	below 60
	Perinatal mortality	67 (1976)			30.35
2.	Crude death rate	Around 14	12	10.4	9.0
3.	Pre-school child (1-5 yrs.) mortality	24 (1976-77)	20-24	15-20	10
4.	Maternal mortality rate	4-5 (1976)	3-4		below 2
5.	Life expectancy at birth (yrs.)	Male 52.6 (1976-81)	55.1	57.6	64
		Female 51.6 (1976-81)	54.3	57.1	64
6.	Babies with birth weight below 2500 gms. (%)	30	25	18	10
7.	Crude birth rate	Around 35	31	27.0	21.0
8.	Effective couple protection (%)	23.6 (March '82)	37.0	42.0	60.0
9.	Net Reproduction Rate (NRR)	1.48	1.34	1.17	1.0
10.	Growth rate (annual)	2.24 (1971-81)	1.90	1.66	1.20
11.	Family size	4.4 (1975)	3.8		2.3
12.	Pregnant mothers receiving ante-natal care (%)	40-50	50-60	60-75	100
13.	Deliveries by trained birth attendants (%)	30-35	50	80	100
14.	Immunization status (% coverage)				
	TT (for pregnant women)	20	60	100	100
	TT (for school children)				
	10 yrs.		40	100	100
	16 yrs.	20	60	100	100
	DPT (children below 3 yrs.)	25	70	85	85
	Polio (infants)	5	50	70	85
	BCG (infants)	65	70	80	85
	DT (new school entrants (5-6 years)	20	80	85	85
	Typhoid (new school entrants 5-6 years)	2	70	85	85
15.	Leprosy-percentage of diseases arrested cases out of these detected	20	40	60	80
16.	TB-percentage of disease arrested cases out of those detected	50	60	75	90
17.	Blindness—incidence of (%)	1.4	1	.0.7	0.3

* The Infant Mortality rate of 114 per thousand live births has already been achieved in 1980 according to sample Registration Bulletin, Vol. XVII, No. 2, December 1983, Registrar General India, GOI. Source : NIHFW Report of the Working Group, Jan. '85)

XII. MONITORING AND REVIEW OF PROGRESS

It would be of crucial importance to monitor and periodically review the success of the efforts made and the results achieved.

Towards this end, the current level of achievement as well as the broad indicators for the achievement of certain basic health and family welfare goals are set out in the tabular statement.

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The Voluntary Health Association of India (VHAI) is a secular non-profit organisation established in 1974. The main objective of the association is to strengthen existing health programmes by creating an awareness about the health situation in the country. Its major activities are: production of books, pamphlets, flash cards, flannel graphs, film strips and slides on basic health care for the use of various health functionaries at the village level; campaigns on issues such as drugs, tobacco, baby foods etc; documentation of relevant materials for the use of activists, and training workshops and programmes for Community Development and Community Health Workers.

BROAD APPROACHES TO RESTRUCTURE THE HEALTH SERVICES

1. Organised support of volunteers, auxillaries, paramedical and multipurpose workers
2. Selection & training of community health volunteers
3. Building of self reliance & effective community participation
4. Establishment of a well worked out referral system
5. Establishment of a nation wide chain of sanitary-cum-epidemiological stations
6. Concept of domiciliary and field camp approach
7. Devising planned programmes to reduce governmental expenditure & fully utilizing untapped resources
8. Setting up centres to provide speciality and superspeciality services
9. Mental Health care and care of physically handicapped
10. Priority to unpriviledged and vulnerable section of society
11. Ensuring adequate mobility of personnel of all levels of functioning.